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PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes the

SEVENTEENTH MEETING

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

VOLUME I

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at The Westin Cincinnati, 21 East Fifth Street, Cincinnati, Ohio, on August 18, 2003.

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C O N T E N T S

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P A R T I C I P A N T S

(By Group, in Alphabetical Order)

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Mr. David Sundin, NIOSH

Mr. Peter Turcic, DOL

Dr. Jim Neton, NIOSH

Mr. Mark Griffon, Workgroup Chair

STAFF/VENDORS

CORI HOMER, Committee Management Specialist, NIOSH
STEVEN RAY GREEN, Certified Merit Court Reporter

AUDIENCE PARTICIPANTS

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JOHN ALEXANDER
EULA BINGHAM
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HELEN BUELIN
JULIA DEHART
JOHN DEMENT
LOU DOLL
JAMES EAST
RUSS HENSHAW
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BOB TABOR
RICHARD TOOHEY
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DAVID UTTERBACK

P R O C E E D I N G S

(1:00 p.m.)

REGISTRATION AND WELCOME

DR. ZIEMER: Good morning, everyone. Now let me call the meeting to order. This is the 17th meeting of the Advisory Board on Radiation and Worker Health meeting here in Cincinnati. I'm Paul Ziemer, Chair of the Board. The Board members are here at the table, with the exception of Leon, who apparently will not be able to attend today, but the other members here are assembled. And for those who are visiting or are members of the public, the names of the Board members -- as you've already discovered -- are on the placards in front of them so I will not introduce them individually at this time.

We do welcome members of the public and ask that if you wish to address the Board at the designated time during this meeting that you register in the book that's in the rear to let us know of your intentions to make a public statement.

We also ask that all here attending -- Board members, staff and members of the public --

please register your attendance, as well, in the other registration book that's back on the table.

Also as is our custom, we have a number of handouts, items -- some of which are on the agenda, some of which are from previous meetings. I believe they're all on the table in the back, is my understanding, so you can peruse that table at your leisure and pick up those items that are of interest to you.

At this time then I'll call on Larry Elliott to make further comments and perhaps an official welcome to Cincinnati.

MR. ELLIOTT: Good afternoon, everyone. Good to see all the Board members back here in Cincinnati. Meeting 17 -- my, we've covered a lot of ground and done a lot of work, and we certainly all appreciate -- at NIOSH we all appreciate your labors and efforts.

I'd like to also welcome the public, and we're looking forward to a productive day-and-a-half meeting.

Some of the Advisory Board members attended a training session this morning in the NIOSH Taft Laboratory offices, working in our database tracking system, getting an understanding of

that. And the rest of the Advisory Board will finish up the same type of training on Wednesday morning, and then I believe everybody will have had a chance to benefit from that experience.

So we're -- again, we're glad you're here. We're looking forward to a day and a half together. And if there's anything that we can help you with or get for you or provide during your stay, don't hesitate to ask. Thanks.

DR. ZIEMER: Thank you. I did fail to mention that this new mike system, you do have to push the on/off button, and perhaps you're aware of that, but just a reminder to all the Board members as you're preparing to speak.

Now we have in our packet a couple of sets of minutes -- minutes -- actually three sets, minutes of meeting 14, 15 and 16. Now I need to determine whether or not the Board members are in fact ready to act upon these minutes. The Chair has gone through them carefully -- and actually I've done a lot of editing on them before they have come to you, so they are about one-half the length they originally were. You may think as you read them that I have removed all of your pertinent comments, but in fact we refer you to

the transcript if you want details on some items. But nevertheless, you have three sets of minutes. It's not obvious to me at this point whether or not you've actually had these in your hands long enough to review them.

If the Board wishes, we can defer action till tomorrow, but let me ask that question first. Are you ready to act on any or all of these minutes? Or are there any who wish to defer if you've not had a chance, those that perhaps just flew in today?

Mark Griffon?

MR. GRIFFON: Yeah, I'd like to defer.

DR. ZIEMER: You'd like to defer?

MR. GRIFFON: I just got them this morning, so...

DR. ZIEMER: Is there any objection to deferring the formal adoption of the minutes until our working session tomorrow?

(No responses)

There appears to be no objection, so without objection the Chair will rule that we will defer action on these minutes until our working session tomorrow. Now that's with the understanding that everyone then will read them carefully this

evening and be prepared for action. Thank you.

Incidentally, on the minutes, let me add this point, that if you have minor typographicals, you can simply pass those along to Cori. We're looking, in terms of adoption of the minutes, for significant changes in content or meaning as opposed to minor editorials.

Let us then move on to the next item on the agenda, which is our regular program status report. Dave Sundin is I believe on the agenda for that. Dave? Please.

PROGRAM STATUS REPORT

MR. SUNDIN: Can you hear me all right? Well, thanks, Dr. Ziemer, and I'll second Larry's welcome again to -- back to Cincinnati for I think the 14th face-to-face but 17th full Board meeting -- so who's counting?

I'll be presenting a brief overview of the program status and I'll follow the basic approach I've used in previous Board meetings. I'm beginning to wonder if maybe the format is being outstripped by the capabilities of our web site because as I returned from leave this week I realized that what I had put together before going on leave was already out of date. So I'll

try and point out where I was able to discover any significant changes in the numbers off of our web site this morning, but again, the web is certainly a very good way to keep current with many aspects of our program.

Well, the Department of Labor has transferred over 13,000 cases to NIOSH for dose reconstruction since we began operations in -- way back in October, 2001. You can see the breakdown by years. And as you're probably well familiar by now, we're continuing to contact each and every claimant involved in a case which comes over to us, and also their authorized representatives, if any. We send an introductory letter, fact sheet, brochure on what dose reconstruction means, and a refrigerator magnet with contact information.

We also, of course -- and we think this is important -- identify a specific name of a public health advisor that's going to represent their interests which our case -- while their case is with us for dose reconstruction, and that's really the primary point of contact for the claimant to get personal information on the status of their claim.

We also introduce ORAU in this introductory letter. We explain ORAU's role in the process, and we provide the ORAU toll-free number as an additional point of contact for them to use.

Recently with our office move we began sending out -- have started, and maybe finished by now -- sending out a letter, an update letter, giving out our new telephone contact information in our new office spaces.

After we make that initial contact of course, we log the case into our computer system. We're still scanning each and every document we receive as a -- along with creating and maintaining a paper filing system. And I will say that our data management systems continue to serve us very well in this program. They're quite key to our ability to pull up a case quickly, to access it from remote locations throughout our contractor staff. And we do have a good crew of ITC specialists that are continually tweaking the system to provide us with technical solutions to problems that we -- or challenges that we confront in managing our end of the process more efficiently.

As you can see, the percentage of cases that

involve AWE employees has stayed relatively constant over time, 14 to 16 percent.

I tried to make this chart a little more eye-friendly than last time by showing -- this shows the trend in cases received from DOL, and this includes of course all four District Offices that submit cases to us, so I broke it down by quarter instead of month. And the number of cases peaked at around 2,800, I guess -- slightly more than 2,800 in the fourth quarter of last fiscal year and has trended generally downward since then. Of course, again, as you know by now, each case file lists the verified covered sites where the Energy employees worked that the DOL has verified, and then we use that information to direct our requests for radiation exposure information to the appropriate DOE points of contact. And in many places the employee worked at several sites, and so we may need to direct our requests to several points of contact. We try and issue those requests within two weeks of getting the referral from DOL.

Give you a little update with where we are with requesting and receiving information from our DOE points of contact. We've sent out more

than 13,000 requests. This number also tends to change fairly rapidly on our web site. Those 13,000 requests actually represent a smaller number of cases, representing about 11,700-something by now cases. And of course the reason for that is that certain people worked at more than one site. We've received approximately 17,000 responses, and that's more than the number of requests we've sent. The most apparent reason and most common reason that we get more responses than requests is that certain DOE sites in particular send us several responses to our initial request. They will respond separately with the X-ray information, for example, from the RADCON information or the exposure information. Some sites I believe also -- we get separate requests from subcontractors that they then send us separately, so that accounts for that difference there. But the responses received represent 9,600 cases, and not all of those cases have a complete set of responses back, so we're not necessarily ready to go forward on that number.

About 12 percent of our requests are more than 60 days outstanding, and we do highlight

that information to our DOE points of contact in periodic e-mail updates. And it looked to me when I got back that one had another update -- or request -- or a status update had been sent out to the DOE points of contact last week.

This table profiles how many requests for personal exposure information we're waiting on from the -- or how our requests are going really for the big eight DOE offices, and how many responses we've currently received. Both ORAU and NIOSH are really continuing to work fairly closely with DOE's Office of Worker Advocacy and certainly very closely with each designated point of contact at the site to make sure that we're getting precisely the kind of exposure information we need to go forward with those reconstructions.

The telephone interview which is offered to each claimant to permit them to add information which may be relevant to reconstructing their radiation dose is depicted here. ORAU has made significant progress in completing telephone interviews and there are now more than 6,000 for which at least one interview has been completed. That's updated as of this morning.

We've conducted also several secure interviews using appropriately cleared interviewers in a secured location to address concerns that have been raised by the claimants.

Of course this has all run up to the punch line, I guess, because all of our work at NIOSH and ORAU is directed to getting a final dose reconstruction report back in DOL's hands. And I am happy to be able to report to you that the number of completed dose reconstructions being sent back to DOL for final adjudication is continuing to increase steadily. There've been -- there's currently nearly 12,000 cases -- or 1,200 cases currently assigned to a health physicist for dose reconstruction. Draft dose reconstruction reports are in the hands of 127 claimants. And as of this morning, 350 of them have been approved by the claimants and returned as final dose reconstructions to DOL. And of course that includes the complete administrative record, in addition to the dose reconstruction report.

I believe that when I last spoke to you -- to the full Board in Oak Ridge, the bottom number was 73, so we've made some progress since that

meeting. We clearly recognize that this is what people's eyes are focused on, including our own, and it continues to rise. But of course everyone wants us to rise as quickly as we can and still do our job.

Really, site profiles are key to our ability to complete significant numbers of dose reconstructions, and ORAU's assembled teams to develop these documents for all the major DOE and AWE sites. As you're aware, the Bethlehem Steel site profile's been approved. The Savannah River Site document has also recently been approved. Dr. Neton will provide you with more details on technical basis documents and site profiles tomorrow.

Claimants continue to phone us and contact us by letter and e-mail, as we want them to be able to do. The number of phone calls received in OCAS has increased substantially each quarter, although I believe it's actually leveled out this last quarter. We're currently receiving about 80 calls a day -- in OCAS, anyway -- so we've responded to over 40,000 calls since October. ORAU is also now receiving and initiating a substantial number of calls, many of which are of

course related to the interview process.

Our web site continues we think to be valuable, not only to claimants, but to the general public. And we field a fair number of claimant e-mails to our OCAS in-box -- over 1,900 actually e-mails have been received since the program got started. And we do try to respond to each of those in a timely manner.

So just to wrap it up, I'd like to draw your attention to some recent developments and accomplishments which I think are worth noting. DOE has asked that we appoint additional physicians to the physician panels to evaluate claims under Subtitle D, and we recently transmitted a list of 44 additional physicians to DOE, which brought the total number of physicians that we've appointed to 123. And we've had a number of discussions with DOE about their need for additional physicians to serve on the panels, and last week we initiated yet another call for nominations of interested and qualified physicians. So we'll soon be evaluating additional applications from people who are interested in being considered for those panels.

We're also interested in assisting DOE in any

way we can in identifying any process improvements that may make the physician panels operate more efficiently.

As I mentioned, the site profile teams have been staffed up and are developing data. You'll hear more about ORAU activities, including the current version of the negotiated production goals, from Dr. Toohey tomorrow, I believe.

A draft of the Residual Contamination Final Report, and this covers DOE, AWE and beryllium vendor facilities, has been prepared and it's undergoing review.

And finally, all of the OCAS staff is -- in Cincinnati, anyway -- is currently -- has recently moved into one building, the Taft Laboratory, which some of you have already been to, of course. And I think I speak for more than just myself when I say that we're all glad to be located in offices that are more proximate to each other than we were previously -- and certainly in many cases, nicer than what we were in before. And we're looking forward to the improvements in our processes that we believe this will bring, so I hope you have a chance -- those of you that can -- to visit our new

environment during either this visit or any future visits you might have to Cincinnati.

So that concludes my prepared report. If you have questions, I'd be happy to try and answer them.

DR. ZIEMER: Thank you very much, David. Let me start the questioning by asking, on the physician panels has there been a sort of an upper limit number identified, either by NIOSH or DOE? The number seems to be growing. Where will the cap be?

MR. SUNDIN: DOE has requested up to 500 physicians. Now our response to that was we did not believe that we could identify 500 physicians that possess the qualifications that we were looking for. And I think during subsequent discussions with DOE, it became clearer that it was pretty early in the process to be sort of working out capacity calculations based on the relatively small number of start-up claims that these newly-formed panels had seen. So I don't think we've really arrived at a consensus with DOE about the total number, but we did hear that figure sort of expressed by DOE at one point.

DR. ZIEMER: Jim has a question.

DR. MELIUS: Yeah, a few questions. One, back to the issue of receiving exposure records from the Department of Energy. If I recall right from the last time you spoke that the main problem sites were the -- I thought were the two I's, Iowa and Idaho, though I don't think Iowa's one you mentioned in -- discussion. Can you -- I notice that Idaho still seems to be a problem and I don't know what the status is of Iowa.

MR. SUNDIN: Well, Iowa's a little bit of a different site. Amarillo actually handles some of the Iowa cases that went to Pantex.

DR. MELIUS: Uh-huh.

MR. SUNDIN: But Iowa itself, we've been working hard to get an appropriate contact point that has authority to turn the records over to us, and DOE's been helpful in that process. But it turns out that the Department of Defense actually is now in a position to provide us records, so I don't know that they've begun to flow, but it looks like we've I believe removed some of the obstacles to obtaining those records that we were hearing about by just contacting the Burlington site.

DR. MELIUS: 'Cause what I recall, there were

a significant number of cases --

MR. SUNDIN: Yeah, it's not -- it wouldn't be, I don't --

DR. MELIUS: -- some hundreds, but --

MR. SUNDIN: -- think it would be sufficient to get them on this list. I don't know, it's around 500 probably, though.

DR. MELIUS: Okay.

MR. SUNDIN: Yeah.

DR. MELIUS: Do that. And then Idaho, what's the -- 'cause that still seems to be a fairly large number of case-- of requests that are half a year or whatever.

MR. SUNDIN: Yeah, the problem there was the need to index a rather large volume of records in a way that would permit them to retrieve records, so they've been spending a fair amount of time doing the basic indexing that apparently was not done at the time, so -- I've not sat in on any recent discussions with Iowa's -- or I mean INEEL folks, so I don't know how that's actually coming along. But once that's done, then the responses should start flowing to us, so -- go fairly smoothly.

DR. MELIUS: Okay. That -- if I understand

your numbers right, the backlog is still continuing to climb of cases -- at least in -- if measured by completion --

MR. SUNDIN: Sure.

DR. MELIUS: -- the case -- cases going. And my understanding also is that DOL is -- even though the number of cases coming into DOL are down, there are certainly efforts on the part of DOL to encourage more people that are eligible to file, to file, so --

MR. SUNDIN: Sure.

DR. MELIUS: -- I'm not sure we expect the down -- cases to continue to decrease, given the long history and the potential backlog. Is there some sense of -- and maybe this is more appropriate for later presentation, I'm not sure how you're set up today, but when do you expect to be at least, you know, decreasing the backlog? Right now you're not, I don't think, even keeping up with what's coming in, and it's -- and what sort of measures do you have, other than completed cases, to say that you are catching up with that? I don't remember the numbers from last time for the number of interviews done or number of dose reconstructions assigned, and I

don't know if that's a meaningful statistic in terms of measuring progress internally. So do you have some indicators that would say now we're getting -- going to get caught up with the backlog or catching up or we're going to get ahead of that?

MR. SUNDIN: Uh-huh. I didn't try and build that into my presentation because we are going to hear from Dr. Toohey about I think pretty much the topic you're asking --

DR. MELIUS: Okay.

MR. SUNDIN: -- that is, the plans to reduce the backlog. I will say, though, that the numbers that precede the final completed dose reconstruction have been -- if you go back and compare, there's quite a bit of improvement there. They're not the final answer, obviously, but they are a necessary step to get done. So things are lining up. I know you've probably heard this for several Board meetings, but certainly there are more and more cases that are headed toward final dose reconstruction.

DR. MELIUS: Uh-huh.

MR. SUNDIN: Technical basis documents are very, very key here, too.

DR. MELIUS: Yeah, I think I -- yeah, we talked about this last time, but I think it would be useful, both internally and as well as for the Board, to have some indicators of that that could be presented, other than final cases.

My final question is -- and again, this may be deferred until Jim Neton's presentation, but I'm a little bit confused by what your strategy -- overall strategy is to deal with the backlog, not process-wise, but in terms of how you're going to triage that backlog. Is it going to -- for this first group, you've -- really, the large number of -- high proportion of these first 300 or so cases have been really from one site and based -- based on a -- you know, a -- essentially a site profile, a dose reconstruction for that site. Are you planning to go through them by site now, based on site profiles? Is it going to be first come/first served, just based on who -- who applied? I just don't see what the strategy is. Or is it some mix of that in order to deal with these numbers and do it?

MR. SUNDIN: It is a mix of that, and I think you are going to get the kind of specific information you're asking for tomorrow.

DR. MELIUS: Okay.

MR. SUNDIN: It's not -- it's not site-by-site, exactly. It's -- I guess my quick sort of overview of the process of sequencing things is we'd like to do the greatest good for the greatest number of people in the quickest amount of time, so we may not have a perfect strategy to do all of those things at once, but it's not -- you know, it's intended to develop the sites where the larger numbers of claimants come from, where the data seems to be good enough to do that so that we get the kind of output that everybody wants.

DR. MELIUS: Uh-huh.

MR. SUNDIN: But I believe there's a couple of discussions, at lea-- well, at least one discussion tomorrow which will give you a lot more detail on that.

DR. MELIUS: Well, I just -- one comment is that that -- if you only do the high-number sites and the ones that are easiest to do -- not that any of them are easy -- then what happens to the people that are at a low-profile site that end up applying, you know, two years ago or whatever, and -- you know.

MR. SUNDIN: Right. Well, it is a mixed strategy, and it is an attempt at doing the best things. But there are specific focuses of activity on precisely the kind of people that -- that might be forgotten under a strictly large site-oriented approach, and there are specific teams working that angle.

DR. MELIUS: Okay. I'll hold off until we hear. Okay.

DR. ZIEMER: Thank you. Wanda Munn is next, and then Roy. Okay?

MS. MUNN: I would just wonder where can the Board see the specific requirements that DOE has identified for the physicians it wants?

MR. SUNDIN: Actually, the rule lays out very minimal I think, if any, requirements on qualification of physicians. It's NIOSH's role to determine what qualifications we believe would equip a physician to operate on a physician panel. We've sent that -- it's styled as an announcement on the physician panels, which -- and it contains a segment in there, evaluation criteria or words to that effect. It's been sent out to the two major occupational medicine societies. It's also on at least one list or --

which a lot of occ. physicians visit. We've sent it to anybody that we think might be in a position to either nominate other colleagues or submit a nomination themselves. I don't know that it's up on our web site, though. It's --

MS. MUNN: I wouldn't think it would need to be. I was just wondering where we might find it.

MR. SUNDIN: I can certainly bring a copy of that to you later today or tomorrow.

MS. MUNN: I'd appreciate that. Thank you.

MR. ELLIOTT: We can get it to all the Board members. We can send that to you.

MS. MUNN: Thank you.

DR. ZIEMER: Roy?

DR. DEHART: Thank you. Dave, on the telephone interviews, it's a voluntary activity on the part of the claimant.

MR. SUNDIN: Yes.

DR. ZIEMER: Are you having any denials? Is it significant at all? Refusals?

MR. SUNDIN: Some. I haven't been tracking that number as a specific item, but in talking to the ORAU people that are doing the interviews, they've described a few denials, but not very many.

DR. DEHART: Okay. So it's not really impacting the program as far as --

MR. SUNDIN: No.

DR. ZIEMER: -- you can judge.

MR. SUNDIN: Not -- not in my judgment, no.

DR. DEHART: I believe it was in Oak Ridge that an optimistic goal for dose reconstruction was going to be 6,000 at the end of the year. Is that still an optimistic goal?

MR. SUNDIN: It is an overly-optimistic goal, I think.

DR. DEHART: Perhaps tomorrow when we're talking more specifically --

MR. SUNDIN: Right.

DR. DEHART: -- we could get a new estimate.

MR. SUNDIN: Yes. I think that's the -- the plan is to have that information presented to you tomorrow.

DR. DEHART: We had talked a couple of meetings ago about the program for the physician panel, and it was talked about possibly having a briefing on that so that the Board could understand better what we're talking about in terms of this number.

You have mentioned the number of physicians

who have been selected or identified to the panel, but does that include the ones who have withdrawn?

MR. SUNDIN: It does include the ones who have withdrawn, so in fact there are fewer than 123 physicians that are currently available to work. But we've asked DOE for a current roster of those physicians that have no withdrawn, and also a listing of those that have received cases. And a little bit better understanding at our end is to -- what we should be looking for, what their process really entails, so I cannot tell you exactly how many have withdrawn. DOE mentioned that they'd had a handful of physicians withdraw, but I did not get the sense that it was a large number.

DR. DEHART: Okay. Thank you.

DR. ZIEMER: Mark?

MR. GRIFFON: And just a quick follow-up on the interviews, I'm wondering if you did any aggregate analysis of the interviews, the phone interviews. You have a lot of them now completed. Is there any attempt underway to do any aggregate analysis for that, possibly to feed into this worker profile database that's being

developed? Or is that even a -- on the radar? I don't know.

MR. SUNDIN: I'm not -- I don't believe we have any plans for aggregate -- are you talking about the content of the interviews or --

MR. GRIFFON: Yeah.

MR. SUNDIN: -- the sort of overall performance?

MR. GRIFFON: No, the content of the interviews. I imagine -- I don't recall the form itself, but I know it did have lists of isotopes and areas where people worked and --

MR. SUNDIN: Yeah.

MR. GRIFFON: -- I thought then there may be some usefulness to doing some sort of aggregate analysis of that data, but I don't know if that's...

MR. SUNDIN: I don't believe we've pushed that one down the road much at all. I mean there is a place where coworkers can be identified, and then of course we go follow up there, but that's not quite the -- what you're talking about. It's building a profile.

MR. GRIFFON: Yeah, right. Okay.

DR. ZIEMER: Rich Espinosa.

MR. ESPINOSA: On the backlog of -- the backlog of dose reconstructions, what's the -- how is ORAU taking care of that? What's their plan?

MR. SUNDIN: Well, I believe the second day of the agenda has a specific presentation by Dr. Toohey, so I -- which includes -- which I believe will be covered during that session. Yeah.

DR. ZIEMER: Rich, are you okay deferring that answer till tomorrow?

MR. ESPINOSA: Yeah, I just didn't see it on the agenda.

DR. ZIEMER: Okay. Thank you. Did you have another question then, Rich? No. Okay. Then back to Jim.

DR. MELIUS: At the last meeting some discussion about the issue of some sort of interim communication to the claimants about the status of their claims or why the -- was delayed. Now you said -- you men-- you sent out a notification about the office being moved. Did that include any information on their claims or do you have plans to do some sort of update for the claimants?

MR. SUNDIN: No, we didn't include a broader

communication piece in that update to our contact information. We wanted to get that out to them as quickly as we could so that they could contact us when they wanted to. We have been having internal discussions involving health communication specialists about how to craft -- what the message should be and how to craft it in a way that's going to be most useful to the claimant. So the plan is still live, but we've not yet put together the communication piece that we believe will work.

DR. ZIEMER: Thank you. Rich, I didn't see what -- did you put your sign by up or were -- no. Okay. Okay, Jim is back.

DR. MELIUS: One other question. Staffing, where do you stand in terms of filling your positions and staffing.

MR. SUNDIN: I think we've got only one or two vacancies left -- four. Four, Larry says. I tell you, it's amazing what a week away from the office will do to your brain.

Rough numbers, between 40 and 45 OCAS staff now.

DR. ZIEMER: Are there any further questions then at this time?

(No responses)

Apparently not. I thank you very much, David, for that update.

I'm going to suggest that if Jim -- if Jim's in the room, that we go ahead with the next item before the break, which is the status of the procurement. It's not a long item. We're a little ahead of schedule. Jim Neton?

MR. ELLIOTT: You've got an old one.

DR. ZIEMER: Oh --

MR. ELLIOTT: You've got to go by the book; you've got an old one there. Pete Turcic from DOL. DOL's going to do it.

DR. ZIEMER: Dave, you think it's bad when you're out of the office. I've been on vacation, too, and I'm looking at my old agenda. So what's on the agenda here?

MR. ELLIOTT: Pete Turcic from DOL.

DR. ZIEMER: This is Cincinnati. Right?

DR. MELIUS: We were beginning to think you're out to lunch, not to vacation.

DR. ZIEMER: Thank you. Okay. Peter, wasn't meaning to overlook you. Thank you.

DOL PROGRAM STATUS REPORT

MR. TURCIC: Okay. It's a pleasure to be

here this afternoon and to give you an update on where the Department of Labor is on their aspects of administering the EEOICPA.

We believe that we have established a credible program, along with NIOSH and DOE, and we've made payments in all facets of the program now. We've made payments for beryllium, for SEC cancer and non-SEC cancer and also silicosis. We've forged good working relationships with NIOSH, Department of Justice, DOE, Social Security Administration, the contractors and the labor unions, and we try to build on that as time goes on. And we've paid out, as of last week, in -- over $628 million in compensation benefits.

And we've completed initial processing -- and by initial processing, we call that either referral to NIOSH -- because we've made a decision that it was a covered illness with a covered employment -- or recommended a decision. And we've processed -- we've issued initial decisions in a little bit over 90 percent of the claims -- the -- in excess of 45,000 claims that we have received since the beginning of the program.

As far as administration of the program, we

have about 300 full-time equivalents working on the program at this time. And that does not count the contractor staff that we have working in the outreach areas.

The number and types of claims that we've received to date, again, we've received over 45,000 claims, and we're anticipating receiving another 15,000 to 20,000 through this year. Of those, as you can see, the vast majority are cancer.

Beryllium sensitivity and beryllium account for about 4,000. One point there is that our claims from beryllium vendors or subcontractors of beryllium vendors have dropped off to almost nothing. You know, I think we've received maybe 40 claims from beryllium vendors, so we're going to be doing a lot of focusing this year on outreach efforts and try to get to, you know, some of these pockets of claimants that we have not heard from. And RECA and in other, about 22,000 claims.

And that's just a breakdown showing the total claims and the types of -- as you can see, vast majority are cancer and other. The breakdown has been holding pretty steady now, with about 57

percent of our claims coming from survivors as opposed to employees.

And the status of our cases, the current cases, we have -- we've referred 13,700 for dose reconstruction. We currently have a little bit over 1,800 that are pending a final decision. That means that there's been a recommended decision and we're either waiting or in the process of writing a final decision, waiting to see if the claimant either objects to the decision and asks for a hearing or a review of the written record or waives their objections.

Final decisions in almost 18,000 cases, and we're currently processing -- our working inventory seems to be hanging around 4,000 cases. That would be the time period, you know, from the time the case is filed until we get a initial decision.

And again, the -- by far, our denials. Most of our denials are still for non-covered conditions, and these are just some of the major ones. And this has been holding pretty steady -- other lung conditions, other heart failure, no condition reported. That seems to have climbed a lot recently where we're getting a number of

claims where -- mostly from facilities that people think are either going to be closed soon or a contractor change or whatever, and a lot of people, when they're retiring, they're just filing a claim. And a lot of them are no covered conditions, so we want to do some outreach in that area to try to get the word out that there is no statute of limitations. People don't have to do that. They're not buying their place in -- you know, setting a place in time, so...

Of the final decisions, again, not -- nearly 9,500 to approve, 12,500 to deny. Again, most common reason for denying is non-covered condition.

The recommended decisions, again, 9,700 for approvals, 14,600 for denials, over 13,000 in for dose reconstruction. We made 8,500 payments in excess of $628 million and we've paid about -- over $14 million in medical benefits -- and that's starting to really increase now that people are starting to have their bills paid by us, their medical bills, as opposed to some other insurance.

And the breakdown on denials of the final decisions, again -- they're the ones that approve

of the denials. As you can see, of the 12,500 denials, over 8,000 are for non-covered conditions. And everything else, you know, drops down substantially beyond that. And that just shows about 57 percent of the final decisions are being denied at this point in time.

One of the things that we track in our goals that we've -- performance goals that we've established for our District Offices is we've set -- we have two different time frames for reaching that initial decision. One for cases that involve an AWE, a beryllium vendor or a DOE subcontractor, which our goal there is 180 days to have 75 percent of the cases completed within 180 days, initial decision. And then 120 days for those that are for a -- from a DOE facility.

To show what we've done this year, because what we did was we focused early on this fiscal year to eliminate -- and our goal was to eliminate our backlog, so we have completely eliminated any backlog of cases and we're now basically working on a working inventory. As you can see, the average time for the first quarter when we were getting that first group that, you know -- we had 18,000 claims, you know, on July

31st. Once we worked through all that, the first quarter of this year our average time was about 242 days. Went down in the second quarter down to 212, and now we're operating and getting an initial decision in about 142 days.

For DOE facilities, again, very similar. Started out 176 days. We're down to in about 64 days. You know, if we get a employment verification and -- on the average, we are getting that case either to NIOSH or a recommended decision within about 64 days on the average.

And the status of the claims, again, the case is returned from NIOSH -- and these are slightly different than the numbers because this is anything that comes back, for whatever reason. We start out with 293 -- and the time frames could be different, too -- had completed dose reconstructions and 162 dose reconstruction was not required. That could have been like a CLL case or some other issue. Or maybe we found out that it wasn't ready to go to NIOSH, we found more employment or, in several cases, we got information back from National Cancer Institute that something that originally we weren't calling

one of the specified cancers are now considered a specified cancer.

Recommended decisions, we have -- or acceptances in 115 of those and 147 are denials, recommended denials; and final decisions, 100 to accept and -- what was that -- and 38 to deny.

Our plans -- I guess I shouldn't have put that number up, but -- the plans to complete the approximately 4,000 dose reconstructions that ORAU is projecting that they will complete this year, our goal and what we hold our districts to is that we want to have -- we give them on the average of 21 days in order to have -- once we receive a dose reconstruction back from NIOSH, to have a recommended decision. And then the time from that would be the same, you know, depending on if it was -- you know, if the claimant is asking for a review of the record or a hearing, then that -- actually that time can change significantly.

And we have committed and have come up with a plan where we will shift cases. I mean because of the way they're going to come back, they're going to come back in large numbers from a certain facility, so like for example, when

Savannah River -- a big in-rush of Savannah River cases hit our Jacksonville office, what we have done, we have paired up each of our District Offices. If we get an overload, we will move cases for a recommended decision -- to do the probability of causation, write the recommended decision and, you know, share it between two District Offices, and then the case would go back and be administered in the original District Office. So that will be seamless to the -- you know, to the claimant.

Just to give you some idea of some of the -- you know, in the Cleveland area, our Cleveland District Office, here are the major -- the major sites that our Cleveland District Office handles. As you can see, the area that it -- the geographic area that it covers, it's most-- you know, mostly AWEs and beryllium vendors for the Cleveland office. And again, these are just a number of -- the percentage, the worker population and the percentage of claims. As you can see, they're very low from this in the Cleveland District Office.

The work sites in Ohio, the status -- total claims, 3,400 and 1,000 for dose reconstruction,

with about 1,500 recommended decisions and 1,300 final decisions. And we've paid about $105 million in the state of Ohio. And the case load from Ohio, again, about 95 cases are waiting a final decision and there's about 968 that are under process from the state of Ohio. And the types of claims are pretty consistent again. You know, over 2,300 are cancer, vast majority are the cancer claims. Chronic beryllium disease, here -- you know, in Ohio we have a significant amount. The lion's share of the beryllium cases are out of the Cleveland District Office.

DR. ZIEMER: All right. Thank you. Thank you very much, Peter. Our first question will come from Dr. Roessler.

DR. ROESSLER: I think just for the record, let's go back to your second slide. I think you have a very large mistake on it --

DR. ZIEMER: A million million?

DR. ROESSLER: Yeah. I think that should be corrected. You've paid out a little over $628 million --

MR. TURCIC: Million.

DR. ROESSLER: -- but not million million.

MR. TURCIC: Yeah.

DR. ROESSLER: Yeah.

MR. TURCIC: All right. Thank you.

DR. ZIEMER: Roy DeHart.

DR. DEHART: Thank you. When you were discussing beryllium sensitivity --

MR. TURCIC: Uh-huh.

DR. DEHART: -- if I'm correct, that does not pay out any -- any bonus or pay or -- it only implies that there will be ongoing medical evaluations.

MR. TURCIC: That's correct.

DR. DEHART: Is that correct?

MR. TURCIC: That's correct.

DR. ZIEMER: Jim, you have a question?

DR. MELIUS: Yeah, I believe when Shelby spoke to us at the last -- I think it was at the last meeting -- in Oak Ridge, he mentioned that the amount being paid out for medical reimbursement's been relatively small and that you were trying to take steps to encourage that, as well as sort of clarify this issue about non-covered conditions and so forth. Can you speak a little bit about your outreach on those types of issues, what you're doing?

MR. TURCIC: Yeah, we just had one area that

we were having a big problem with that was up in Alaska and we were just up in Alaska and we found that some of the problem was with the pharmacies. Pharmacies didn't want to take our card and so we've been doing some outreach there. In fact, we'll be back up there at the end of the month meeting with the medical providers and trying to get more of them signed up.

The other things that we have done is that we'll go into an area and we recently did one in Paducah, Kentucky with the union, the -- and in an effort to try to get more people, more claimants, to have their bills billed to us. That was a -- that's a big issue. So we're -- we've also done a mailing to everyone who is entitled to medical benefits and put together a packet so that -- of information with cards in it so they can pull it out and have a handy way of access to our -- our medical provid-- bill-paying, phone numbers and assistance.

DR. ZIEMER: Roy DeHart again.

DR. DEHART: A follow-up question on that. What fee structure are you using to reimburse providers and the pharmacy? Are you using Medicare or some other kind of --

MR. TURCIC: We're -- we're way above Medicare. We're significantly above Medicare.

DR. DEHART: Not hard to do.

MR. TURCIC: We have -- pardon me?

DR. DEHART: Not hard to do.

MR. TURCIC: Yeah. What we do is eventually we'll have the system programmed so that we'll be able to do regional fee schedule. Right now we do a national cap. And I believe the cap is set on somewhere in California, so it's pretty high in a lot of areas. So that -- the fee schedule is -- we've -- we're way above Medicare and most other insurance companies.

DR. DEHART: So I gather you're moving toward a usual and customary.

MR. TURCIC: Yeah -- well, it is a usual and customary, but it's based on a -- it's based on the fee schedule from California.

DR. DEHART: Yes, okay. I'm familiar with that -- you're probably going to be able to get some providers that way. Thank you.

MR. TURCIC: Yeah.

DR. ZIEMER: Additional questions or comments?

(No responses)

Thank you very much, Peter. Appreciate the update.

Now perhaps we could go ahead with Jim Neton, if Jim is here. We're still ahead of schedule. Jim, are you here?

DR. NETON: My and Mark's presentations sort of go together, though. I don't know if it might be --

DR. ZIEMER: Okay.

(Whereupon, Dr. Neton and Mr. Griffon discussed the order of their presentations with Dr. Ziemer, off the record.)

DR. ZIEMER: The Chair will rule that it's time for a break, and so -- but we will confine the break again to -- we'll let it go 20 minutes. How does that sound? 'Cause they do have to do a little discussion during the break. So 20-minute break and then we'll reconvene. Thank you.

(Whereupon, a recess was taken.)

DR. ZIEMER: We're going to call the meeting back to order. As you know, the Board has been searching for a contractor to assist in the review process -- that is, the audit, as it were -- of dose reconstructions. And Jim Neton is going to report on the status of that

procurement, and then we'll follow that with a discussion on the task order development. Okay? Jim.

STATUS OF PROCUREMENT

DR. NETON: Okay. Thank you, Dr. Ziemer. I'd like to preface my remarks by saying I can only discuss this to the extent the procurement regulations allow, so if I seem -- appear to be sketchy, that's because that's what the Federal Acquisitions Regulations require.

I am happy to report that we did receive more than one proposal for the task order contract, so that allowed us to move forward for an evaluation. We assembled a technical evaluation panel. That panel has met twice by teleconference to do the technical evaluation and scoring of the proposals that we received. Based on that scoring, we established -- with input from our Pittsburgh grants office -- a competitive range. And the proposals that made the competitive range we went forward with and did a request for a past-performance evaluation. So we're at the past-performance evaluation stage.

I just got off the phone with our secretaries

over at the Taft Building and we have received the past-performance evaluations for the proposals that remain in the competitive range, so they're being FedExed to the technical evaluation panel members this afternoon.

We can review those past-performance proposals, and once we do that, re-evaluate or re-establish the competitive range for the proposals. And at the same time, we're shipping out the cost proposals and we will then review the cost proposals and make our recommendation to procurement as to our selection based on technical merit.

We establish a score based on technical merit, and then we put feedback in on the cost proposals to procurement. So we're at that stage.

We should be able to wrap this -- well, it's possible this could be wrapped up fairly quickly if we do not enter negotiations, either singular or multiple, with vendors. So we're very close. It could be within a matter of -- we may be able to meet or original projected time line, which is by the end of this fiscal year. So that's where we're at.

If there's any questions, I can answer them at this time. Otherwise, I think Mark is prepared to talk about the fleshing-out of the task orders.

DR. ZIEMER: Any questions?

(No responses)

Okay. Thank you, Jim, for that status report. Then Mark, if you'll proceed then with the task order development. And there is a handout. It's been sent around the table. There are copies for the public's -- perhaps on the table by now. It's a single-sheet Power Point handout.

(Pause)

DOSE RECONSTRUCTION WORKGROUP AND BOARD DISCUSSION TO DEVELOP TASK ORDER

MR. GRIFFON: Get my refresher training on the system here. You'll notice that I -- I tend to use the black and white overheads 'cause I usually develop these on the plane ride out here, so no fancy colors with this.

This is just a status report on where our working group is. The tasks -- we developed draft procedures for the review process, and that's how we're going to go forward with the

individual case reviews. And you may not remember this, but we had a procedure -- on the next slide I'll go through some of what that procedure contained -- on how we were going to go forward with the individual case reviews. Actually Cori's making copies right now for the Board and we're going to give that out as homework here. I'd really like to get comments from the Board tomorrow on that procedure, you know, so mark it up -- read through it tonight, and if you can, mark it up. Now that we know a little more of how this is going forward, I think we'll probably be modifying that a little bit.

The second thing was the procedure for the selection process, and I sort of separated those out, review versus the selection. And if you remember, last meeting I brought up Excel spreadsheet, which was a little busy as an overhead, I must admit. But it was the way we're going to sort of matrix how we were going to select cases -- by site, by cancer type, by radiation type, et cetera -- and how we were sort of going to fill in these boxes as we went along, depending on what cases were in the hopper, what cases were completed, and going through the whole

process that would drive how we were going to fill this matrix in, with the ultimate goal of around two and a half percent of the overall cases we were going to do -- we were going to review about two and a half percent of the overall cases.

And then the last thing was develop individual task orders, and I think these were at the back table, as well as handed out to the Board members. When you first came in you probably noticed those few pages. And we had drafted these at the last meeting and we got some feedback and reformatting from NIOSH on these. And the hope is that we'll get these tasks completed prior -- or right around when the contract is awarded so we can get the tasks out right away to the contractor or contractors to bid on.

And the two tasks right now that we have are individual dose reconstruction review, basic and advanced; and the methods review, the procedures review. Okay?

So this is that first -- the procedure for the dose reconstruction review process, some of what it contains. We have a section on how we're

going to select cases in there, how we're going to designate Board members for the review, and the distribution of the data, interaction between the contractors and the Board, the report generation -- if you're a member, we also had some draft reports; three different levels, the individual reports, the summary reports and then the Board report to HHS. We talked about three different sort of levels of reporting. And then the Board recommendations to NIOSH regarding individual cases and also aggregate -- you know, do we have general findings from what we've reviewed.

And then the case selection procedure, we just briefly had our working group meet over the break. We're going to reconvene tomorrow morning. I've -- I've started to structure another procedure on this along -- to go along with that matrix that I -- that I put up at last meeting and -- just to have some language on -- and some of the things we want to consider in this are the case availability. I think that -- obviously we've got to understand a little bit about how NIOSH is -- is proceeding so we know what cases might be coming avail-- you know,

coming up. We're not going to review cases until they're completed, and so we have to look at case availability.

The case selection criteria we're going to outline in the -- in this procedure, as well; sampling strategy. The case assignment process, I think we have to -- you know, there's some logistics involved here. There's also a question about the Advisory Board's conflicts of interest, so we have to figure out first of all who wants to work on different cases and then who can work on certain cases, so -- and then -- and how they will work with the contractor.

And then the tracking process, and again, some things to think about here are, you know, who's going to do the tracking? Are we going to have an established subcommittee or working group? Will NIOSH do the tracking for the Board? You know, how is that going to work? And also along with this, defining the scope of the -- of the individual task. That might actually be misplaced a little, but I'll come up to this point again. The idea here is that as -- as these tasks are released to the contractor, they're going to come back with a proposed scope

of work. And the question here is is the Board's responsibilities versus NIOSH's responsibilities. NIOSH is the contractor. We as a Board I think want to control it to some extent, the scope of work. Maybe not the financials of the contract, but at least the scope of what the contractor will be doing. So we have to figure out how -- where those lines of responsibility lie.

Okay. And this --

DR. ZIEMER: Mark, let me interrupt a minute. Might I ask if the -- if the Board members have questions as you proceed --

MR. GRIFFON: Sure.

DR. ZIEMER: -- would you like them to raise them at that point rather than wait till the end?

MR. GRIFFON: That's fine, yeah. Yeah.

DR. ZIEMER: Then let me ask --

MR. GRIFFON: That means you have a question.

DR. ZIEMER: -- a question. On the tracking process --

MR. GRIFFON: Yeah.

DR. ZIEMER: -- is there any reason why the Board's contractor wouldn't do the tracking that you're talking about versus NIOSH itself? What's -- we're just tracking the cases that the Board

is reviewing here. Right? Is that what you're --

MR. GRIFFON: We're tracking the cases that we're reviewing, but also we're tracking them against the matrix that we've established up front. So say we wanted to do 30 Savannah River cases overall, but we also wanted certain other criteria to be met. So you know, as we fill in those blanks -- and we may not do all 30 Savannah River cases, you know, up front, so -- you know, it's tracking sort of what we've done versus what were -- our goal is. And I guess the contractor could be tasked with that responsibility, too, yeah -- yeah, so...

So this is the task orders, as I -- I think I mentioned this already, that two of the task orders have been drafted, the methods review and the individual dose reconstruction review task orders. A lot of the language was lifted right from the original contract that we -- the proposal that we let out. The one that I think we need to -- and we're going to work on more tomorrow morning with out working group is the site profile task. And that -- right now we have sort of very broad language about what we mean by

site profile review, and I think we need to fine-tune some of that. We're going to work on that and try to get at least a rough draft to the full Board tomorrow morning on that.

Like the commitments I'm making for us? Good.

Discussion items. Some of these were at our last meeting, too, and I think we touched on some of them. But I think we certainly haven't resolved all of them.

The Board and the contractor access to data, and by this I mean, you know, NIOSH data as well as possibly other data -- DOE data. There are some questions that have been raised in previous meetings about Privacy Act issues, whether we can get this data on CDs, so I think we -- we need to explore that and -- you know, this was also kind of a question for NIOSH, if there was an update on that, on those questions.

The Board and the contractor access to site personnel and/or NIOSH staff. And site personnel, I mean DOE or -- primarily DOE site personnel and NIOSH staff that worked on either the site profile or on the individual dose reconstructions, whether they can go back to

those resources and talk to them about assumptions, et cetera, in the cases.

This one had a lot of discussion in the early going. We dropped this from our original proposal, but the Board and contractor access to claimants for follow-up. And I think we really need to -- we said after we put the contract out we'd bring this up again, and I think we need to discuss it more, whether the Board feels it's necessary to do follow-up with the claimants about their phone interviews and the issues surrounding that question, I guess I think we need to discuss as a Board. And also the -- what would it take to allow the Board to do that. So that one I think we need to -- further discussion on that.

And then the Board recommendations from individual case review reports and summary reports. This really is the -- I think this goes into that -- some of those draft reports we discussed. How do we communicate this to NIOSH, to HHS, for the aggregate findings as well as for individual case findings. I think when we're talking about individual case findings, it's more of a case where it would have made a difference

between a favorable claim versus unfavorable claim.

And then establish a process for the Board to review contractor's response to individual tasks. That's what I -- what I raised a few minutes ago, the question of -- maybe not very clearly stated there, but the question of who -- or where the lines of responsibility for defining -- or refining the scope that the contractor agrees to do under a certain task, so -- so if they bid on the methods and procedures review but their language -- some might feel is broader than was in the original proposal, how do we refin-- you know, who has the responsibility of refining that language and making sure it's -- you know, and where is the line. I know that NIOSH is the primary contractor, but I think that we on the Board have a interest in making sure we keep the technical scope appropriate.

And I think that's it.

DR. ZIEMER: Okay. Thanks, Mark. Let me ask if other members of the subgroup want to add anything or... Yes, Roy?

DR. DEHART: It's not really an add, but Mark, do you have any feel about when we're going

to have -- have to have this information specific so that when the bids are complete and everything is done, when we're going to get this forwarded to the contractor and start this kind of review?

DR. ZIEMER: Jim Neton can give us an estimate of when we might be ready with a con-- the earliest date we could have a contract in hand sort of thing.

DR. NETON: Boy, I wish Martha -- Martha DiMuzio were here, she could probably answer that better than I. But if all goes and we don't end up going through negotiations with the contractor -- I mean we review the past-performance proposals and the pricing -- cost proposals and we just select a vendor, I mean that could happen in a matter of a week or two. Matter of fact, I think our responses are requested back by next Monday to the contracts. So I don't know. I can't speak for them how long it would take them to process and get an award out the door, but I would think it would be a matter of several weeks after that. And upon award of the contract, I see no reason why we couldn't issue a task order, particularly if it's --

MR. GRIFFON: So you're talking --

DR. NETON: -- going to be very soon.

MR. GRIFFON: -- maybe early October or --

DR. NETON: Yeah, I would think early October. And Larry, you might have a better sense, but I would see -- it's possible. I can't promise that.

MR. GRIFFON: Yeah, and that's why -- I think we have two tasks sort of in rough draft form, if folks can look at those tonight, as well, and give some feedback on that. I have already got some comments from NIOSH. I'm going to take those comments into account -- modify it a little bit and bring a new draft tomorrow as well on those, and those are covering the individual, basic and advanced reviews, as well as the methods and procedures review, something to get started on. I think I really want to get a rough draft of the site profile review task out, as well, so --

DR. ZIEMER: Larry has an additional comment here.

MR. ELLIOTT: I think that October is a good date for you to target your efforts toward. I fully expect that the contract will be awarded by then. That's what we're all striving for.

I think also that as you think about developing these tasks you should add a task for their contractor to do the tracking, the monitoring assignment. That's not something NIOSH should do nor wants to do. We have plenty of work of our own. We could certainly help, but I don't want to take that on. And I think it's best if your contractor does that for you, but that would have to be done under a task.

The other thing I need some clarification on in my own mind is -- you were talking just before your concluding remarks about this defining the scope issue. I'm lost on that. The scope of work is defined in the award. Are you talking about scope within the task?

MR. GRIFFON: Yes.

MR. ELLIOTT: Okay. That helps me understand then. Okay.

MR. GRIFFON: I'm sorry.

MR. ELLIOTT: 'Cause you mentioned something about some proposals seemed to be broad or overly-broad beyond maybe what you're thinking of in a task scope, I guess.

MR. GRIFFON: No, no, no. No, no, no, I said -- I said if -- if a proposal to a task was

broader than we thought the task entailed -- in other words, the contractor went beyond --

MR. ELLIOTT: Okay, I understand. To talk process here, the contract's awarded let's say first of October. You're going to need to think about having a meeting with your contractor to present your tasks. And then it -- usually the way this business is done, you give the contractor two weeks to prepare a proposal against that task. You evaluate the proposal, and then there's -- if there's any negotiating that needs to be done at that point, you do it and you refine either the task or the -- typically what's refined is the proposal against the task, not the task itself.

MR. GRIFFON: Right.

MR. ELLIOTT: So you refine the proposal to where you want it to be.

MR. GRIFFON: That's what I meant. Probably not very well-stated, but that's what I meant.

MR. ELLIOTT: You're in the driver's seat on that, not NIOSH. That's this Board. So as you think about the process, you're going to have to think about the timing. You're going to have to think about whether you can do this without the

full Board. And we're going to have to think along with you about whether or not some of this needs to be done in closed session. So there's a lot of work to be done in preparing the -- just to issue these tasks in a final form.

MR. GRIFFON: Right.

MR. ELLIOTT: So -- and we're here and we're glad to help you do that. But I just -- I want you to all think in that -- those kind of frameworks.

DR. ZIEMER: Thank you for that clarification. And along those lines, we may need in fact to get opinion of counsel on the extent to which this Board can delegate some of those activities to a working group, for example -- for example, to do an evaluation or to sit down with a contractor or whether in fact that needs to be the whole Board in open session or in executive session.

MR. GRIFFON: Right.

DR. ZIEMER: And I don't know if this is something that we might ask legal counsel to take a look at, at least give us an early heads-up on what might be coming in that regard. Okay?

Anything else at this point, Mark? You're

going to have a distribution for tonight's homework assignment, is that what we understood?

MR. GRIFFON: That's right. That's right.

DR. ZIEMER: Or does everybody have a copy right now?

MR. GRIFFON: I mean I don't know if now is the time, but I think we need a discussion on the question as to whether to re-interview, to have the Board or the contractor get access to the claimants.

DR. ZIEMER: I'm -- let me give an early answer to that, and this is not so much an answer as an idea that -- I'm wondering if we would have a better feel for whether or not -- well, before we get into an extensive debate on this, 'cause we had extensive debate before on that issue. When we get into the review process, it might become evident one way or the other whether or not such interviews would in fact be needed or helpful. We may find that -- from the established record and other documentation that such interviews would not be required or would be very important, depending on what we find. So I'm not sure that we necessarily need to reach conclusion on that right now. Is there any

reason we need to come to closure on that at this point? 'Cause it could be handled in a task at some point later. Jim?

DR. MELIUS: If I recall right, and this goes back several months when we first had some discussion of this issue, I think we deferred it a little bit until we were -- those of us who had not seen the database system and had not seen the records had had an opportunity to look at them. Now some of us had our training this morning, a number of others are having -- that's certainly one of the things I spent some time looking at was trying to get a handle was based on the interview record that's available in the NIOSH database, which is a summary document of the interview -- electronic summary. To what extent is that -- is that an adequate document for -- to do a -- you know, a dose review. And I think for the other group that's having a -- their training on Wednesday morning, I think that's something they should also look at 'cause I think -- I don't think we -- I'm very hesitant to wait until we get part-way through the review process because I would be -- I think it would put NIOSH and everyone in a bad position to have a partial

review from the Board. The Board -- the dose reconstructions are fine, but we have questions about the adequacy of our review because we didn't -- weren't able to re-interview and now we need to re-interview. I think to the extent that if we can deal with the issue before we start the review process, I think it would be better for everyone -- for the process itself and for the credibility of our review, rather than having something that we've reviewed it and -- but we still need to go back and look at this. Now -- now our review is never going to be complete, you know, because there's going to be more cases to review and -- as the program goes on. But at the same time I think to the extent that we can we ought to try to make the process as complete and comprehensive as possible up front. Then if we have to modify it later, fine. But I -- I would hesitate on just deferring until we're several months into the review process and then making a decision like that.

I think we also have to remember that if we are to add a follow-up -- some sort of follow-up interview or contact with the claimants, that's going to have to go to OMB for approval. There's

a fair amount of bureaucracy and paperwork to do that and a fair amount of time. So we're talking about something that, you know, realistically is going to take some months to do, even -- once we've agreed on what should be done and how to complete it. So I think -- be another reason to try to, if we can, come to some conclusion on that as soon as possible.

DR. ZIEMER: Any other comments on that issue? Mark?

MR. GRIFFON: And just the other reason for considering it up front instead of waiting is that at several meetings now we've heard concerns about these phone interviews from -- from claimants or representatives of claimants. And -- you know, so I think if we're hearing from the public that they're concerned that the interview didn't capture everything that they -- and I know they have opportunity to respond and correct the record, but we've certainly heard that on testimony a number of times, so I -- you know, I don't know that we really need to wait. And the other concern would be the delay on getting it through the system, the bureaucracy, to get it -- even approval to do it, so...

DR. ZIEMER: Any other comments, either on that issue or related matters? Jim?

DR. MELIUS: I'm just thinking in terms of how we're going to work and work through this process, and even more than about the interview process, I'm concerned that we've got to really sort of -- lot of issues left out there in terms of how we're going to proceed in terms of developing a procedure and a schedule for doing this. And I don't know what the plans are for in terms of further discussions, but to the extent that the work group can try to figure out some of these legal issues and procurement issues and figure out what needs to be done and, you know, what we need to do in terms of subcommittees meeting and so forth, I think it's -- we need to accomplish as much of that as possible by the end of our meeting tomorrow. And I don't know if NIOSH counsel's available to meet or speak about some of these issues or what we need to do in terms of procurement, but seems to me if we don't, either we have to -- if we don't get a good process set up and understood, that we could end up either having to meet as a Board every other week for a while or we're going to have to,

you know -- this is going to get stretched out for a very long time, which I don't think serves the process well.

DR. ZIEMER: Other comments? Wanda?

MS. MUNN: I continue to be concerned over the concept of re-interviews, especially by this Board or some portion of this Board, as being some kind of next-step -- some kind of appeal process, which I believe we've all agreed -- I think we agreed that that was not going to be the case at all. I'm very concerned that as we move down this pathway, it is very clear that this is not an appeal process and that it is in fact a quality assurance process for reviews that have been done, that are selected in a random way, not because of any additional appeal or any additional action on the part of the claimant. Whether such clarification needs to be very clearly spelled out in the statement of work is another issue to me, but as we proceed down this path, I would hope that all the members of the Board would keep that aspect of what we're doing here very clearly in mind, because it's a major concern to me. How things are observed from the claimant point of view is key, I think, here.

DR. ZIEMER: Thank you. Other comments? Gen Roessler.

DR. ROESSLER: Are you reopening discussion of whether it should be done or shouldn't be done, or what point are we at on this?

DR. ZIEMER: We have no formal motion, but the proposal from the working group included the idea that that item needs to be visited and discussed at some point in the future. As I understand it, Jim is suggesting that perhaps that should come later, perhaps as soon as tomorrow -- if I interpreted that correctly. I mean I don't want to misinterpret, but I thought I heard that.

In any event, I think right now we're simply discussing this as a general idea and how that fits in the framework of the task order. So -- and this might be helpful to the working group as they go back and revise things for our perusal tomorrow.

Jim, you --

DR. MELIUS: Yeah, just let me clarify. My belief is our first priority ought to be to get this process underway and figure out how we're going to get a schedule set up, what needs to be

done in terms of legal procurement issues, how do we move forward as a Board to develop and approve these task orders and get them out to the -- whatever contract is chosen.

I think as a second priority, I think we need to deal with this interview issue, and I was as much reacting to Paul's comment that maybe we should wait until we've already gone through -- done some of the reviews and then decide whether we need to do -- to add interviews with the claimants to the process. And I just was remarking that I thought it should be one -- we should at least try to deal with that issue up front. But I think it's really a -- to me, it is a second priority in terms of the getting this process underway and if we can get to it tomorrow, fine. If we can't, we can't. But I think we really need to get the -- figure out the schedule and how this whole process is going to work.

DR. ZIEMER: Okay, thank you for that clarification. And I might add in terms of the interviews, as I see it, if we were to proceed in some manner, either sooner or later on that, it would have to be in the framework of spelling out

what the audit is going to ask for in regard to evaluating interviews. If we have a procedure that spells out for us how we will go about evaluating the quality of the interviews, that might lead us itself to determining whether or not follow-up is needed.

I think I expressed before -- at least I think I did -- that we have to be very careful that we are auditing and not doing the work of NIOSH or ORAU. If there is reason to believe that the audits are inade-- or the interviews are inadequate, and perhaps that would emerge from an audit, then in my view it's NIOSH's duty to go back and correct that issue, which might include on their part re-interviewing. I mean I think of analogies as to how auditors -- with the exception of Andersen, perhaps -- audit books. And they make recommendations, but they don't go back and do the work of the organization. So somewhere there's a fine line in what we will get from that, yeah.

Go ahead, Mark, please respond. I'm talking off the top of my head a bit here, so --

MR. GRIFFON: I don't want to regenerate all the discussion -- we've had discussions on this

before. But I think, you know, part of my notion also is that to -- if you just look at -- if you -- in the final form, you're not necessarily going to see everything that an interviewee brought up. And something that they thought was very significant, the interviewer may not have captured. And then we also in the past have raised the question of if the interviewer didn't have site-specific knowledge, they may have missed something that could have been very relevant. And so therefore re-interviewing a -- and we're talking about -- from the audit standpoint, we're talking about not re-interviewing everyone. We're talking about re-interviewing a small percentage to determine if in fact the form did capture all the relevant information. And we're having -- you know, you also have to -- I mean I do understand that -- you know, even though the form didn't capture every word a person said on the phone, it doesn't mean that it's not a quality final product, so we're asking the audit contractor to work with us and do a sampling of that and say okay, well, yes, it didn't capture every word they said, but it captured all the relevant information. It

looks like they did a fine job on, you know, 95 percent of them or whatever. So that's what I was thinking.

DR. ZIEMER: Yeah. Tony.

DR. ANDRADE: Thank you. I guess perhaps a senior moment here, but I'm trying to recall whether we were really talking about a quality improvement process, which is an extremely important issue to clarify right now, and then also address the question of the types of -- that the kind of re-interview or approach to asking about an interview that has taken place -- what sort of results we expect to get and what sort of metrics we would have for success, so two things.

One, if we are dealing only with cases in which -- that have been closed, adjudicated and settled, then we're not going to -- we are indeed, by definition, not going to go back and open them up again or re-interview, as it were. In other words, if we find that interviews are considered inadequate in general, then that should be clearly stated up front and that will be a quality improvement process for NIOSH-OCAS to deal with. That's number one. So I need to get that clarification from Mark or somebody else

now.

Number two is if indeed we're looking at cases that have been closed, then they've either been adjudicated positively or negatively. And so I can already anticipate the result. Those that have been paid out or positively adjudicated were probably going to get -- or the staff is going to get high marks, and there may be contentious issues with those for which compensation was denied. Therefore, if you're going to start thinking process, then I think in parallel you'd better start thinking about these human issues that you're going to deal with.

So I'd like a response to my first one at least.

DR. ZIEMER: Thank you. Larry is prepared to respond in part.

MR. ELLIOTT: I'll respond to your first com-- question. The Board will only review and its contractor will only review adjudicated claims, those that have been -- a final decision has been proffered, they're not in appeal, they're done. You won't be looking at cases that a recommended decision's been proffered but they're not finally adjudicated. You won't be

looking at appeal cases. You look at those that are finally adjudicated only.

DR. ZIEMER: Right. And Gen?

DR. ROESSLER: The reason I asked if we were still discussing was I wanted to bring up pretty much what Tony has brought up. I can't picture this being an unbiased process. When it's final, if the claim has been denied, there's going to be a -- very much of a bias toward -- whether they think there's an appeal or not, toward a criticism of the process. If the award has been made, that person I think is just going to want to just say it's done; I don't have any comments. I don't know if that's -- I think that may be a bias, too. So I can't really see and I guess I'd like to be convinced of this because I can see some of the motivation for wanting to evaluate it. But I can't see much but down sides to it.

DR. ZIEMER: Jim?

DR. MELIUS: Yeah. I think as we've discussed this before, my understanding is this is not a consumer satisfaction survey that's being done, so we're not going to ask questions of, you know, was the interviewer nice to you, you know, polite and were you happy with the

results. It's -- I think the issue is whether obtaining additional information from the claimant would have some effect or potential effect on the case. Was there additional information that was relevant to the dose reconstruction to be obtained. And that that would have to be -- the relevancy of that information would be assessed. So yes, would there be a claimant that would say, you know, some information wasn't considered. There may be even claimants that did get compensated, may be confused about why they got compensated, so it's not an easy process necessarily to understand, particularly for people -- worked a multiple sites or multiple cancers and so forth. So -- but I don't see this being done as a way of measuring consumer satisfaction. It's really is there relevant information that was -- or different information or whatever that was -- be relevant to the claim and would have changed the way the dose reconstruction would have done in either direction. It may not be necessarily to find higher doses or whatever.

DR. ZIEMER: Thank you. Tony?

DR. ANDRADE: Thank you. I don't see it as a

consumer satis-- if we go through with this process and it's approved and we put it into place, I don't see it ever being a consumer satisfaction interview or re-interview, either. But I just can't help but feel that the mechanisms that are in place today -- that is, a quality check and the transcript check by the interviewee of the sorts of -- well, okay, the information, the information that was tracked and that was actually written down, okay, is one pretty good indicator to the interviewee as to whether information was -- important information was captured or not. And again, I'm shifting over from just being completely factual to now the more human side of this. Somebody who's been denied is going to -- we're going to have to be extremely careful in dealing with somebody who's been denied a claim, whether the person was a petitioner or was a survivor. There are going to be strong sensitivities, strong emotions and -- let's put it this way. I wouldn't be the contractor to bid on doing that kind of work.

DR. ZIEMER: Let me suggest again to the work group that they give further thought to developing the criteria for which the interviews

will in fact be evaluated. I think that'll be helpful to us. What are the measures that will be used to initially -- assuming you had the power to do interviews, how are you going to, as a starting point, evaluate the material that's in the file. And if you were -- had the power to interview, how would you decide which ones you would do? Is it all of them that are being reviewed or are there certain criteria that would trigger to say we -- there's something here that triggers us to think that either something was omitted or left out or what. I'm trying to get a feel for some sort of standard operating procedures by which we would evaluate to start with and then go from there. Jim, can you add --

DR. MELIUS: Well, no, I just want to clarify back to our original discussion, and I don't think this has changed. There is no transcript or recording of the interview, so that can't be referred to. All we have is the report from the interviewer. There's no routine process for going back and doing quality control on the interview process itself, as might be done, you know, in other types of studies or whatever, interview studies and so forth. So you know,

what we have is only from basically one person interviewing. The only sort of quality control or whatever you want to call it is the fact that the record of the interview is sent to the interviewee for review and comment and they can send it back. So that's the one quality controls check. I think -- and that's the process we're being asked to look at. Were some of these other things in place, were there transcripts of it, that might very well change how we would want to go about doing our quality control, quality assurance that we're mandated to do.

DR. ZIEMER: I guess what I would be -- and I understand those points. I guess what I would be looking for, you know, as a starting point, the claimant at some point agrees that -- either agrees or disagrees that the trans-- not transcript, the summary captures the information. I would be -- if it were me -- looking for some evidence that the claimant finally agreed to that out of frustration rather than well, you know, I can't get this claim going unless I finally sign this thing, or something like that, as opposed to everybody agreeing that the information has been captured. I mean if the claimant is agreeing

that the interview has captured the information, then -- then it becomes a matter of do we have other information that the claimant didn't know about in any event, which might -- which might very well be. There might have been something occur on that site, maybe it's in the site profile, that the claimant knows nothing about, and that's not a deficiency in the interview process, per se. So again, that's why I'm trying to get a feel for how we go about, as a starting point, evaluating interviews. It seems to me we can't just arbitrarily say that -- well, maybe we can -- that they are faulty because there's no transcript. I'm not willing to say that as an a priori condition if the claimant is willing to say that the content has been captured. So I would more be looking for some evidence that the claimant is sort of browbeat into that position or enters it out of frustration or some other factor. So help me out.

DR. MELIUS: Well, I don't think that's necessarily what we're looking for evidence of. I think we have to remember that these claimants are of limited education in many cases, have limited understanding of the processes that they

were involved in. They were sworn to secrecy about what they were being exposed to and were given, you know, relatively little information in many cases about their exposures. To then go back, you know, 40 years later or 30 years later and then try to ask them to -- you know, interview them and have them, you know, recreate the -- what happened to them, what their exposures were is I think a very challenging process from any perspective. And I think that is what we're trying to assess. I'm not -- I think it's going to be very hard for this process to look at is there a bad interviewer. I mean our review process is just not -- you know, is there a -- were they being coerced in some way or being ignored. I mean that's a very hard -- hard to get at, but I think there really is an issue of what kind of information is being ascertained in the interview, given those circumstances and given the information available, given the time frame that's gone by and so forth. And I think we have to take a serious look at how that -- how that's being one. And I mean there are reasons why a transcript isn't being kept. I just think that limits our ability to review the process.

I'm not saying that that's -- should be required, but it's something that might have -- if it had been -- if it were available, then maybe we would think of other approaches.

DR. ZIEMER: Well, perhaps you've made my point for me, and that is that given then -- in many cases, the limited knowledge of the people being interviewed, that how do we in fact determine whether or not the interview is adequate? I think you're asking in a sense the same question. How do we determine adequacy, that's what I'm asking. What are our measures? So --

DR. MELIUS: I agree.

DR. ZIEMER: Yeah. Okay. Roy.

DR. DEHART: I think the point of audit is to assure that the interview has captured any corrections that is later made by the subject. In other words, the interview is given. He or she or the family says no, this is not complete and blah, blah, blah, and lists three or four additional things. Has that additional information been incorporated in the process. That we can do with the record, and I think that's appropriate to do with the record.

DR. ZIEMER: Thank you. And that certainly would be one measure that one could look at, as well. Uh-huh. Other discussion on this item or any of the related work group recommendation?

(No responses)

Okay. Mark, remind us again what it is we're going to get tonight for our bedtime reading.

MR. GRIFFON: Yeah, Cori's got it right now.

DR. ZIEMER: You want that to be distributed at this time?

MR. GRIFFON: Yes. Yes, it's the review process, the procedure for review process. And if you could take some time and red-line that tonight, we can discuss that tomorrow.

DR. ZIEMER: So were there any other comments you have on this at this time or has -- it's pretty well been covered. Okay. Thank you very much.

Any final comments on development of the task order?

(No responses)

PUBLIC COMMENT PERIOD

Thank you. Then we'll move on with our agenda. We're a little bit ahead of time, but I think we will proceed with public comment period.

I have just one request so far. I will open the floor after that. Denise Brock is with us again from St. Louis. Denise, I drove by the arch yesterday, but I didn't stop. But we're glad to see you again and --

MS. BROCK: Thank you.

DR. ZIEMER: -- pleased to hear your comments.

MS. BROCK: Thank you. And I am here today on behalf of my mother -- again, Evelyn Cofelt -- and also on behalf of all the Mallinckrodt claimants.

Before I forget, though, I just want to speak to what you all were discussing. What I did during my mother's telephone interview was just got a voice-activated recorder and I used a speaker phone, and that's what we used actually after we got our draft or hard copy back to go back over, and we had our notes in front of us, and I'm sure not everybody is quite that extreme when they do things, that's just my personality. But that's what we did and we sort of went over that process to make sure that everything that was asked was touched upon and -- and it was basically a summary, and we had a few kinks in it

that were eventually corrected.

But I agree with Dr. Melius. These workers had no idea what they were exposed to in most cases. I mean there were code names. I think I mentioned that before -- tube alloy, biscuit -- they didn't know about transuranics and things like that. So I really don't know what sort of questions to -- that you would even ask in a situation like that. I mean I'm kind of on the other end of it.

I do have a letter from one of -- I call them my claimants -- and this is a female. She didn't want her name mentioned, but at the end of it -- and I don't know how pertinent this is, but she says (Reading) I worked nine years for a company that I had no idea what was being done there. Yes, I knew it had to do with uranium, but I don't think any one of us had any clue as to the dangers of this uranium or the presence of other chemicals and what it could do to our bodies. I had no reason not to trust Mallinckrodt or the Atomic Energy Commission. When I first read about the compensation and why it was being given, I felt anger and disappointment that our government had put us in harm's way without our

knowledge or consent. Thank you for listening to my statement.

And that's just part two of her letter. But I think that that seems to be not an anomaly. I don't think these people knew what they were exposed to. And then years later we have all these sick or deceased individuals.

And as far as the process itself, would there not be a way perhaps for NIOSH or ORAU or whoever is conducting the interview itself to somehow record that? I mean -- because I mean we could try to tell all the claimants to try to get a speaker phone and a voice-activated recorder, but I think it would be much easier for somehow the Federal officials to -- to record these. Is that a possibility?

DR. ZIEMER: Thank you, Denise. I think we've addressed that before and perhaps one of the Federal officials will address it again. Did you have additional comments that --

MS. BROCK: Oh, yes, I do.

DR. ZIEMER: Okay, please -- please proceed and then we'll --

MS. BROCK: And that's another thing I wanted to say is that this is probably going to be quite

lengthy, so if at any time you need to cut me off, that's fine. I'll be here tomorrow, too.

Today I have some comments I'd like to make that are rather personal, and I also have some questions that I'd like to raise with the Board. I don't know if anybody prefers which I do first -- okay, then I'll just start. Again, the comments I have to make at this beginning part are personal. The remaining amount will be as to the Mallinckrodt claimants.

August 15th, Friday, was my father's birthday. My father's been dead since 1978, so obviously we've went through many birthdays without him. But this year seemed to be a little bit different, and I think that's for numerous reasons. Probably one because of this whole process that I've been doing for a little while now.

But secondly, there's been a lot of publicity in the state of Missouri with what I'm doing. Poor Larry I think has gotten part of that because I know that they call him, the reporters and senators and so on and so forth. But in the process of that, I have met some very wonderful people and one woman reporter has just been

amazing. Her name's Gerri Dryling*. She did a *Riverfront Times* article in St. Louis, very lengthy article. She's very empathetic, just a wonderful person.

And in doing that, there's a lot of questions that are asked that brings up a lot of memories. In one way it's therapeutic, but in another way it -- it brings up a lot of things that maybe you wouldn't really want to remember. And that's when I'm going back to my father's birthday or Christmases that we spent. And I'd just like to say that as a child I grew up knowing my father had cancer. I believe I was probably five or six when he was diagnosed with lung cancer, and I grew up knowing that word.

I grew up knowing the word "terminal", and probably never really, unfortunately, thought much about that. I guess you would say unfortunately. My parents had a very good knack of protecting us. I didn't even know we were poor, but I guess we were. We lost our home due to the financial problems. I mean it ravaged our family. We lost our home, our car, our furniture. And we lived in a really nice house, but I was kind of a goofy kid and thought that

moving to something with wheels on it would be just really an adventure, and that's what we did.

And I never knew that until recently when I talked with my brother that on Christmases -- my father had seven sisters -- and he would do whatever had to, he and my mother of course, to make sure that we had everything we wanted for Christmas. Christmases and birthdays were pretty weird, though, because the biggest part of those, from what I can remember, were spent in a hospital. It was called Barnes Jewish and there was a special area called Queenie Towers is what I remember mostly. And I can remember being pretty young and sitting on the floor playing with Barbie dolls on Christmas day. And there would be a tree in his room and sometimes a priest giving him last rites or his sisters being around him.

I can even remember leaving the room at one time for whatever reason I had to leave, and I had a -- this is silly. I had a purse that had this long fringe on it, I just loved it, and my dad was in the hospital and he -- I knew he bought these things. They were called Little Kiddle dolls. They were these little bitty dolls

with like a bubble over them. And when I left the room I had went to the downstairs part of the hospital by myself and was actually robbed. Somebody stole my purse. I think I was probably about seven or eight.

Those are the kind of memories I have, along with remembering that when I was old enough sometimes my brother and I would be home alone with my father. And back then they had those real big oxygen tanks where you had to adjust the knob to get the right flow of oxygen. He had Tupperware containers full of medication. I know it sounds silly now, but when we were little I would be afraid that maybe I turned it up too high to too low or gave him the wrong medicine at the wrong time.

Sometimes I remember being afraid -- sorry -- thinking that if he slept too soundly maybe he'd be dead, and I wouldn't want to go in the room. But I had a younger brother, so I would make a lot of noise. I didn't care if I got in trouble. I just wanted to -- to hear him. And I would go in and I would shake him really hard, just to hear him, you know.

And that brought me to the day he died, which

is really significant because I don't know if it was out of habit or just being a smart ass, but I can remember standing at my door waiting for the bus. And I hollered to him and he didn't answer. So I thought well, I don't care, I'm going back to his room. I don't care if I miss the bus. I went back and I shook him really hard and I said goodbye, I love you. And he looked at me right in the eye and said I love you, too. And about five hours and ten minutes later, my brother came to school -- I was a senior in high school -- and he walked into my classroom and told me that my father sat up and clutched his chest and died in his arms.

We buried him a couple of days later in a cemetery across the street with a real small headstone. You know, again, I was real young and didn't pay attention to not having anything until maybe -- maybe six months or a year later, phone calls started coming in. Bill collectors, my mom even got served with some sort of subpoena to go to court. They were going to try to get a judgment against her over a headstone.

And now that I think of this stuff and I think about I'm groveling for her for $150,000

from a vendor that poisoned -- and a government that poisoned my father, gave him cancer, it ate and ravaged his body, it just -- to me it's obscene. It's just absolutely obscene and I have no hard feelings against anyone in this room, but I just think it's appalling. This is not an anomaly.

My story -- I didn't tell this for anybody to feel sorry for me. I hear stories like this every day. And I think it's one of the saddest things there is. These people protected their government and died because of that, and now they or their survivors are having to jump through hoops and come up with details of stuff that has been long since destroyed. And again, if this was for me, they could stick it. But this is for my mom who's 80 years old, who lives on under $1,000 a month that can't even afford her medication. And I'm hoping that she gets a check so she can at least live long enough to see that and maybe kind of have some of the burden lifted off of her, as well as the other claimants. Thanks.

And do I have time to ask questions now? Do I? To Larry, is there any idea of the time frame

of when the rule may be finalized in order to petition for Special Exposure Cohort?

MR. ELLIOTT: The rule you're referring to is the rule on adding classes to the Special Exposure --

MS. BROCK: Yes.

MR. ELLIOTT: -- Cohort? And we have been addressing the public comments received under public comment period, redrafting the rule in accordance in how we have addressed those comments. We're hopeful that by the end of the year we will see a new rule issued.

MS. BROCK: Okay, thanks. Also, in a letter to one of my claimants -- I think Dr. Toohey and I touched on this -- from Dr. Toohey, it was dated July 15th, 2003. It stated -- I understand that it is expected to have completed dose reconstructions for most of the Mallinckrodt claimants by this fall.

And also I'd read an e-mail that says by September. Would that -- is that close to accurate? I mean do you expect to have most of these dose reconstructions done by fall or September?

DR. ZIEMER: Yeah, I guess we'll probably get

a detailed report tomorrow on that, but is there a brief answer, Jim?

DR. NETON: Yeah, that's right, tomorrow we're going to talk about the performance plan in a little more detail, and particularly the technical basis documents I'll be addressing tomorrow. But we're very close on the Mallinckrodt technical basis document. I think latest indications are maybe within a week or two the first draft will be available. And once it gets approved by us -- I mean NIOSH has to review it and bless it. Once that's done, then it -- it takes a little while to get the technical basis document implemented. It's not like you can write the document and then tomorrow start generating the dose reconstructions. There's about a month in between there where it needs to be -- the process needs to be worked out a little better.

MS. BROCK: By technical base (sic) document, is that the site profile? I'm sorry, is that what that is?

UNIDENTIFIED: (Inaudible)

MS. BROCK: Okay. And that was my next question, is was it finished. With your site

profile -- I'm curious because I'm just not real familiar with that -- do you also, when you -- when you do those, do you base it on the epidemiological studies that were also done on those facilities?

DR. NETON: No, the site profile is an exposure model. It has nothing to do with the epidemiologic evidence. It has to do with the facts surrounding the source term of the materials that were there, the air sample data, the bioassay data, those type of parameters are included in the document. But the epidemiologic evidence is not included in there. The probability of causation model of course is the model that does the -- that uses the epidemiology. And as we've discussed at past meetings, currently there are no DOE worker epidemiologic studies that are used in the probability of causation model at this time.

MS. BROCK: I guess that kind of confused me a little bit. I've got something that I thought was interesting and I just wanted to comment. It says (Reading) In order to estimate exposure, it is essential to know the amount of a pollutant released to a particular medium such as air or

water from a source pollution, called a source term, or to have an accurate history of concentrations of pollutants in air, water and soil.

So I'm curious, with Mallinckrodt, because there is such a loss of records -- and I understand you state that you have quite a bit on site profile -- but what about situations -- and again, I probably have asked this before -- where you have like the daughter products? I mean like if you have naturally occurring Pu-244 from this Belgian Congo pitchblende and if you have actinium and polonium and the radon, can you -- is that -- is there enough there to get an idea about where this was and how much these people were exposed to if there's not individual data? And if there was not any internal or a lot of internal, there was just breath -- some breath radon and mostly external, is there enough to do that on?

DR. NETON: I think it'll be more evident when the model comes out and -- or the technical basis document or the profile, and it'll be on our web site, by the way, for anyone to evaluate. But the short answer is we try, whenever we know

that there are materials that weren't monitored that were included in the exposures, we'll add them in to the claimant's dose. And that would be reflected in the site profile itself.

As most things go with this program, if we don't know and we have to make a judgment call, then we will err on the side of being favorable to the claimant.

MS. BROCK: Thank you. And to the epi studies, I wanted to ask a question about Elizabeth DuPre Ellis*. I understand that she had published some studies quite some time ago, the mortality studies. It's my understanding she completely excluded internal dose. Is that what you would be looking at, because she also has some non-published -- for some reason, some non-published documents and I was kind of curious why that was non-published. And I also have something -- let me look through my paperwork, but I believe I have something -- there was like 20.8 percent that actually was missing on the published. Which do you use, do you use the published, the non-published?

DR. NETON: Again, back to one of the earlier questions, we would not use the epidemiologic

study to do the dose reconstruction at all. I mean those are independent datasets. And it's true and many times internal dose is difficult to decipher and many epidemiologic studies in the DOE work force have tended to not evaluate the internal dose completely. But we would not be using either of those epi studies to do the dose reconstructions themselves.

MS. BROCK: And I think I just kind of wanted to comment, because I know my concern is also the concern of many of the claimants, probably because we are not scientists or health physicists, but it is very difficult to understand. But I just wanted to read something. (Reading) The Department of Energy occupational epidemiologic studies constitute one of the world's largest and most extensive follow-ups of people exposed to low level ionizing radiation and other substances. The studies were initiated 36 years ago and cover some 600,000 people who worked for Federal contractors at industrial and research sites. These workers helped produce tens of thousands of nuclear weapons for the United States. Many were followed for more than 50 years when the first nuclear weapons were made

during World War II. From the very beginning it was recognized that the risks posed to nuclear weapons workers over time were not well understood. Dr. Robert Stone, the head of the health division of the Manhattan Project, noted that worker radiation protection rested on rather poor experimental evidence. He concluded the whole clinical study of the personnel is one vast experiment. Never before has so large a collection of individuals been exposed to so much irradiation.

And I think sometimes that that's kind of scary for some of us because we're not really sure how accurate the site profiles are and how accurate the epi studies are. And I guess I was rather confused because I -- I know there were -- Merrill Eisenbud* had talked about Harshaw* and Mallinckrodt being the two worst I believe in AEC history. And I understand in one of his biographies he had stated quite a few things to Ms. Dupre Ellis and a lot of that wasn't even commented on in some of her studies, so I think I was a little bit concerned, but I feel better now.

And I also wanted to make comment, and I

don't know -- with the Department of Energy, I think somebody had touched on it earlier about waiting for exposure data to come back to the Department of Labor. I've had a personal experience with the Department of Energy. I think I had spoke to that once before about I had filed a FOIA request, actually several, one on behalf of my father and one on behalf of all of Mallinckrodt -- not had much response at all. But what I did get on behalf of my father, as I stated previously, was from the Department of Energy a document stating that he was under Q clearance, had the issuance date, the termination date, with a letter stating all other files had been destroyed.

A couple of months later, actually June 13th, I receive a letter from the Department of Labor stating DOE has verified his employment. And they had some records -- actually things that I had never gotten and they told me they never had, showed him as a powerhouse operator. They were actually equating the dates of employment with the issuance and termination dates of Q clearance. They -- it was just kind of peculiar to me.

When I asked them about it, they denied it, said it didn't come from them. Well, I have those files and it did come from them. And so my concern here is that if we're waiting for the Department of Energy to come up with records that we can't get -- and I know nobody can comment on this -- but my concern is are they incompetent, are they lying, and is this what we're waiting for for people to base dose reconstruction on? It's very, very disconcerting.

Also I notice that the Department of Energy -- we have something called SLAP, St. Louis Airport storage site, and they had removed the DOE designation off of there -- really nice man, Roger Anders, I called him. I called him repeatedly. And I asked him about that and he said well, he didn't think that DOE had done any cleanup there. And I asked him to give me about ten minutes and I would send him the documents to show that they had. I know they did at least two rounds. And I've done that and they are making a formal change.

But that also scares me, too, because what that does is leave my subcontractors out there who possibly were involved in cleanup without any

remedy.

They also said there was no beryllium there. I've got beryllium added and I'm getting ready to add it to two other sites, as well, because I've got the documents to prove that. So all of this is kind of scary because you've got lay people such as myself -- and this is not my forte -- and I'm having to dig this stuff up to help people.

And talking about reports, the *Labor Tribune*, which is a paper that our unions have for the building and construction trades, did a story and it went out to 90,000 people. So they accidentally put the wrong number in for Paducah so all the claims are coming to my house, so I forward those on. That's all right. My daughter kind of goes insane with it, but I think that that's going to generate numerous claims, as well.

And I don't know if anybody knows, but is it true that the Department of Energy can come in and screen these subcontractors? I've got guys that need to be tested for CBD and for cancer. Do they have some sort of -- I thought they did that in other areas. Can I have them -- somehow get them to come in and test these workers? Are

there mobile units or does anybody even know that?

UNIDENTIFIED: You need to talk to DOE.

MS. BROCK: DOE, yeah. And why is it that DOE is never here? There's never a representative. Is that because this has nothing to do with DOE, because I see the things on the -- no? I really think we should invite them.

And the last thing I think I wanted to say today --

DR. ZIEMER: Incidentally, we have not closed this meeting to DOE, so...

MS. BROCK: And the last thing I wanted to ask today was to please come to St. Louis because I betcha I could fill up a room with at least 400 people for you. Thank you.

DR. ZIEMER: Okay. Thank you, Denise, for your comments.

Okay, we have a request from Richard Miller from GAP. Richard, please address us.

MR. MILLER: Dr. Ziemer, thank you. Good afternoon. My name is Richard Miller. I'm from the Government Accountability Project. I had a couple of brief questions and points. The first is, in reviewing the site profiles I've noticed

that apparently there's a NIOSH version of IMBA, and I wondered whether this could be made available to the public on NIOSH's web site, the way that IREP is available, so that we can take the dose information that is presented and uptake and convert it into individual organ dose. That makes it somewhat difficult to have to find people with IMBA and waste their time running the numbers. And it does seem that if you've purchased such a model, it would be very helpful to the public to have it available so that the site profiles can be converted into something useable for the lay person.

DR. NETON: IMBA currently, as it exists, is a stand-alone program that runs on a PC. I'm not sure that anything precludes it from running as a web-based software, but we would have to check into our licensing agreement with the vendor before we'd even be able to entertain that possibility.

MR. MILLER: Well, at this point then you will have the monopoly on converting the data if it's not made available, so I appreciate you have a licensing issue, but I -- and certainly if you want to -- if you want to have people write in

for a CD, we're happy to do that. But you know, as a -- a task order contract?

DR. NETON: (Inaudible) task order contract will have access to IMBA.

MR. MILLER: Well, that's great, but what about the rest of us? I mean we've got access to IREP. Now unless -- unless -- do we need more than one program? Do we need more than IMBA to be able to convert it? Because I also noticed that there was a second program that was mentioned in the Savannah River, I believe, site profile -- forgive me, I don't have the document with me, but there -- I mean if there's -- whatever program you need to convert dose, you know, that information, whatever -- whatever combination or individuals are, I think it would be immensely valuable. And I think -- otherwise this program's going to lose transparency. Right?

DR. NETON: We can explore that possibility and see what can be done to make that available.

MR. MILLER: Okay, that'd be great. Thank you.

The second question has to do with the -- sort of the shift in the program and the audit.

I remember sitting -- it must be a year ago -- through meetings about the development of the RFP for the audit and what would go into the scope. And what's happened to the program -- at least this is my observation, and maybe it's a mischaracterization, but site profiles were going to be these things out there and there were going to be these worker profiles, and the RFP that went out said you were going to do five sort of worker profile/site profiles I think per year, and then you'll do so many in depth and so many, you know, standard dose reconstructions and so many blind and so forth. But what it looks like now is that as you've gotten more experienced with the program and you've tried to find ways to get some efficiencies, you're doing a lot -- looks like a lot more site profiles than was discussed a year ago when the RFP was in its development stages. And it seems to me at this point -- this is my observation -- that given the high degree of reliance upon the site profiles to inform the dose reconstructions -- and I'm only basing this on having watched what happened with the exposure assessment, at least at Bethlehem since that seems to be the lion's share of the

cases that have cranked through and I have the great pleasure of receiving the phone calls from people who were denied mostly so I get a little bit of insight into some of these cases.

Would it make sense for the Advisory Board -- and it may even be an efficiency method for you all, as well -- to think about auditing all of the site profiles, 'cause there's a discrete fixed population of them, many of which it appears are going to serve as a cookie cutter for "me, too" sites, so your uranium rolling mills, you'll use the basic same method, you know, as tailored. Or the same uranium extraction process where you have phosphate fertilizer plants that also extract uranium and so you'll have a sort of a cookie cutter there, and you can sort of see how this program's shaping around types of production where there's common -- particularly in the AWEs -- some commonality and probably in some of the production sites, the DOE productions sites, to audit all of them. In other words, to think about whether it makes sense.

Now I don't know whether this implicates your RFP or not and your procurement process and its integrity and whether people will come in

complaining after the fact that, you know, they bid on one thing and awarded a contract for another. But you know, I just would sort of float that as a thought, that -- that -- I'm not sure if five site profile reviews are going to be sufficient in the first year if the productivity of these site profiles starts pouring out and they are then the foundation for knocking out scores of dose reconstructions thereafter based on that model. So I would just offer that as a suggestion. You might even be able to audit fewer dose reconstructions but do more site profiles. It just seems that way.

The next -- the next question was -- and maybe this can be addressed tomorrow, but I noticed in the handouts that there was a vast increase in staffing in this program from the last time we saw it in terms of contractor, ORAU staffing. It looked like it was over 250 staff at this point, contractor staff. And it would be very helpful -- if not tomorrow or at some point -- for there to be some discussion about who are these people, where are they, where did they come from. That's a big pump -- are these people employed by DOE contractors today and they're

working as consultants to the program? Are these people who are, you know, retired and they -- consultants? Are they competitors that were disappointed? I mean where did they come from to get such a huge boost in staffing, and are all these people sort of cognizant of kind of the approach to the program and -- and -- and vetted for conflict of interest?

And then the last comment I guess I would offer sort of spoke to Subtitle D. DOE abolished its advisory committee. The Secretary apparently saw fit to eliminate it on January 1st, so what was known as WAACee*, or the Worker Advocacy Advisory Committee, is no more. Which was too bad 'cause it was a pretty distinguished group of individuals.

The problem arises that your program interfaces with that in a very important way, and that is this. There are many radi-- there are many dual filings of claims. I mean people filed under D and B simultaneously, and a number of those are for cancer cases. And what's happening is that the physicians panel are being given cancer cases to evaluate without dose reconstruction or probability of causation

findings. Now DOE has a different standard of causation than this program. This is an as-likely-as-not standard for Subtitle B. Subtitle D is the -- well, by the time they worked out the rule, it was sort of a significant factor which aggravated, caused or contributed to the illness or death. So you have a lower standard of causation under the -- or lower threshold for establishing causation under the DOE program.

Nevertheless, DOE is now sending to physicians claims without the benefit of your work. And it seems to me -- although this is not DOE I'm speaking to and obviously they didn't see fit to come to very many of your meetings, and I don't mind that being put on the record; it sort of shows some kind of indifference which is not lost on the public -- that the dilemma is they're going to now deny claims because there's an absence of information which you all are going to be developing at some point which is either going to be lost or have to be re-adjudicated again with the benefit of your new information. And I don't know whether it's appropriate or not for this body to take up that question, but I think, given that there's 18,000 claims at DOE and there

are at least 4,000 claims that have nothing to do with any radiation-related cancers -- asbestosis, you know, chronic obstructive pulmonary disease from, you know, caustics or whatever -- that it might be appropriate to take that up and wait for y'all's work product before they -- you know, kind of triage matters, I guess that's the nice way of putting it. Because there is a lot of valuable work and investment going into this that will not -- whose fruit will not be enjoyed by another program.

Now I know you don't advise Secretary Abraham nor profess to, but if there's some way to facilitate communication -- I mean really I think, at the risk of being inappropriate here, I believe you're somehow tied to the physicians panels in some respect and maybe --

UNIDENTIFIED: (Inaudible)

MR. MILLER: Yes, I think -- I mean I don't know whether it's possible to give some insight to your colleagues here, but I think it's a huge waste not to take advantage of your work at DOE. We don't have an advisory committee to talk to there anymore, so you're it. Those are my thoughts.

DR. ZIEMER: Thank you, Richard. Any comment?

MR. ELLIOTT: Richard, I appreciate your comments. You're certainly very correct that we, too, would like to see DOE hold the cancer-related claims until our dose reconstructions are finished. And in our coordination with other agencies, we've talked about this. But for this Board's perspective, this is not within your charter. It's not something the Secretary is asking you to do. Richard, your comments are on the record and that's where they can stand and be heard. I think that's enough said.

MR. MILLER: Great, well, we'll -- I mean that's great. I -- I know, it's a hard problem. We used to talk about pushing on a string -- right? -- when you couldn't lower interest rates any further and you still can't push people along. Sometimes I feel like that's where we are. But -- and I will look forward to your response with respect to the IMBA question at -- and see what you can get for us. Thank you.

DR. ZIEMER: Okay. Thank you very much. We're coming to the close of today's session. Let me ask if there's any housekeeping items we

need to address today, Cori, or other staff?

MS. HOMER: Just remove your laptops and bags.

DR. ZIEMER: Don't leave things in this room tonight. Right? Thank you very much.

MR. GRIFFON: One thing, Paul.

DR. ZIEMER: Right.

MR. GRIFFON: Just a question. The working group is going to meet in here at 7:00 -- assuming that the door will be open, in here at 7:30 tomorrow morning, and I would ask maybe if Jim Neton -- I didn't ask Jim before -- if you can meet with our working group tomorrow morning?

DR. NETON: What time?

MR. GRIFFON: 7:30, and possibly somebody to help with the procurement questions, too, legal -- if someone from legal is available --

DR. ZIEMER: Okay, and then --

MR. GRIFFON: -- for our breakfast meeting.

DR. ZIEMER: Right here?

MR. GRIFFON: Yeah.

DR. ZIEMER: And then --

UNIDENTIFIED: Is it going to be open?

MS. HOMER: I'll make sure.

DR. ZIEMER: Yeah. Our open time -- or our

meeting begins at 8:00, which is the -- the normal registration period, with the formal meeting beginning at 8:30.

MR. ELLIOTT: We have that agenda change.

DR. ZIEMER: The agenda change is we will be moving up -- the agenda item that appears as scientific issues work group report, that report is -- will be deferred or at least will not occur tomorrow. I don't know if John Till is prepared to start early, but --

MR. ELLIOTT: Probably not. You'd better let him start when he was scheduled to start.

DR. ZIEMER: Right. So unless John Till wants to start early, and we don't know necessarily that he would even be here at that hour -- well, in any event, we may have to start at 9:00 then, unless there's something we can -- I'm wondering if -- I wonder if -- or perhaps we can move one of these other ones up on this agenda, but I'll work that out separately, so let's plan to begin at 8:30 and we'll just shift things around a little bit.

So we are recessed till tomorrow morning.

(Whereupon, an adjournment was taken to August 19, 2003, at 8:30 a.m.)

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C E R T I F I C A T E

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